PRINTED: 01/12/2015 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155530	A. BUILDING B. WING	E CONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/15/2014		
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX	CROSS-REFERENCED TO THE	SHOULD BE COMPLETION EAPPROPRIATE		
TAG K010000	A Post Survey I Safety Code Re Licensure Survey was conducted I Department of I 42 CFR 483.700 Survey Date: 1 Facility Numbe Provider Numbe AIM Number: Surveyor: Brett Code Specialist At this Life Safe Shore Health & not in complian Participation in CFR Subpart 48 Fire and the 200 Fire Protection Life Safety Code Existing Health 410 IAC 16.2. This one story for basement was deceived.	Revisit (PSR) to the Life certification and State by conducted on 10/16/14 by the Indiana State Health in accordance with (a). 2/15/14 r: 000369 er: 155530 100275190 t Overmyer, Life Safety	K010000		DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING B. WING		12/15/2014
	PROVIDER OR SUPPLIER SHORE HEALTH & REHABILITATION CENTER	353 TY	ADDRESS, CITY, STATE, ZIP CODE LER ST IN 46402	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K010038 SS=E	system with smoke detection on all levels including the corridors, areas open to the corridors, and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 129 with a census of 69 at the time of the survey. Quality Review by Dennis Austill, Life Safety Code Specialist on 12/16/14. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered except for the wooden shed in the back used for maintenance storage. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure two doors in 1 of 1 locked emergency exits were accessible at all times. LSC 7.1.10.1 requires a means of egress shall be continuously maintained free of all obstructions or impediments to full and instant use in case of fire or other emergency. This deficient practice would affect all residents, visitors and staff that reside in the Unit 4 wing.	K010038	The facility will ensure that all doors are accessible at all tim. The exit doors identified during the survey will be repaired. Do will open with little effort. All exitle will be checked to ensure profunctioning. All doors will function to designe will audit doors at least weekly to ensure continue proper functioning. Results of audits will be reported to the Control of the continued compliance.	es g pors xits per tion tor i

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155530			(X2) MU A. BUIL B. WING	DING	NSTRUCTION 01	(X3) DATE (COMPL 12/15/	ETED
NAME OF PROVIDER OR SUPPLIER SOUTH SHORE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 353 TYLER ST GARY, IN 46402				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLES-REFERENCED TO THE APPROPRIATE	
	Findings include: Based on observation and interview with the maintenance director on 12/15/14 at 11:50 a.m., the maintenance director attempted to open the Unit 4 west end egress exit double door. The maintenance director had to push hard on the right side of the door to open. The left side of the door had to be forcibly opened by pushing hard and kicking the door. The maintenance director then had to slam the door to get the door to close properly. The maintenance director acknowledged the aforementioned deficiency. This deficiency was cited on 10/16/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.						
K010044 SS=B	Based on observation facility failed to sets would latch	used, are in accordance	K01	0044	The facility will ensure that all the doors latch into their frames at times. The fire doors identified during the survey will be repair. All fire doors will be checked to ensure proper functioning. All the	all red	01/12/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A DUIL DING 01			COMPLETED	
155530			A. BUILDING B. WING			12/15/2014	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
				353 TYI			
SOUTHS	SHORE HEALTH 8	& REHABILITATION CENTER		GARY, IN 46402			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	separation be p	rotected by fire door			doors will function properly		
	assemblies equ	ipped with door closures			Environmental Director or		
	_	n 7.2.1.8. NFPA 80, the			designee will audit fire doors a	ntinued s of	
		re Doors and Fire			least weekly to ensure continu		
		1.2 requires fire door			proper functioning Results of audits will be reported to the (
		•			Team monthly to ensure		
		nclude latches. NFPA 80,			continued compliance		
	•	all fire doors to be closed			•		
		he time of a fire. This					
	deficient practi	ce affects any resident,					
	visitor, and staf	ff using the Units 2 & 3					
	and the Main D	Dining room					
	Findings include: Based on observation and interview on						
		00 p.m. with the					
		_					
		rector, the fire door with a					
	1 ½ hour fire resistance rating and						
	separated the existing Unit 3 Hall from the Main Dining room had a positive latching mechanism for the door but failed to latch into the frame. This was verified by the maintenance director at the time of observation.						
		or vaccore.					
	This deficiency	y was aited on 10/16/14					
	1	was cited on 10/16/14.					
	The facility failed to implement a systemic plan of correction to prevent reoccurrence.						
	3.1-19(b)						

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